AMESBURY PUBLIC SCHOOLS
EMERGENCY INFORMATION CARD

PLEASE PRINT

Student_____
Last Name First Name MI

Student Address_____
Street City State

Parent 1/Guardian's Name_____

Parent 2/Guardian's Name _____

Student lives with parent(s)? Yes ____ No _____

If not residing with parent, list parent(s) address below:

Parent(s) Name(s):_____

Address: _____

_____

Grade: _____ Home Room:_____

Bus No: _____ Date of Birth:_____

Student's Home Tel: _____

Parent 1/Guardian's Work Tel: _____

Parent 1/Guardian's Cell #: _____

Parent 2/Guardian's Work Tel: _____

Parent 2/Guardian's Cell # _____

Student is a ward of the State? Yes _____ No _____

Siblings attending other Amesbury school:

Siblings name:	School attending:

List two adults who will assume temporary care of your child or pick up your child at school in the event of an illness or family emergency, or at a host facility in the event of an evacuation, if you can not be reached. (If your child is to be dismissed by someone other than you, that person's name must be listed below or you must provide us with a note stating permission to release your child to that person. Otherwise, the child will not be allowed to leave with that person.)

Name: _____Address_____,_____ Tel.# _____
Street City

Name: _____Address_____,_____ Tel.# _____
Street City

If there are individuals to whom the school SHOULD NOT DISMISS YOUR CHILD because there is a legal, updated court document on file with the school, PLEASE LIST BELOW:

Name(s)_____

The following over the counter medications have been approved by our school physician: Tylenol, Ibuprofen (Motrin/Advil), Bacitracin ointment, Caladryl lotion, Antacid tablets, Contact Solution and Benadryl.

I GIVE THE SCHOOL NURSE PERMISSION TO ADMINISTER THE ABOVE OVER THE COUNTER MEDICATIONS AFTER ASSESSMENT.

Parent /Guardian Name:_____ **Parent /Guardian Signature:**_____ **Date:**_____
Please Print

HEALTH UPDATE

Please fill in any information regarding your child's health.

1. Please provide any physician diagnosed serious condition requiring treatment:

Allergies (food, insects, medications, others):_____
(Specify)

Reaction:_____

Treatments:_____

Hearing Problems (specify): Left ear_____ Right ear____Hearing Aids_____

Vision Problems (specify): Wears eyeglasses_____ Contacts_____

2. Any illnesses, injuries or surgery since last school year?

_____

3. Last physical exam?_____Last Dental Exam?_____(Please Provide Copy)

4. List medications and dosages taken on a regular basis @ home_____

_____

INSURANCE INFORMATION

Student's Physician: _____

Tel.#:_____

Student's Dentist: _____

Tel.#:_____

Does your child:

_____receive fluoride ____drink city water

Does your child have Dental Insurance?

Insurance Company Name: _____

Policy #:_____

Does your child have health insurance?_____

Health Insurance Co._____

Policy #:_____

Medications necessary for health conditions and/or allergies must have a written physician's order and written parental permission and be supplied by parent in their original container.

*** In the event of a nuclear emergency my child may receive Potassium Iodide. Check one: ___ Yes ___ No (See reverse side)**

* I hereby authorize you to speak with my family physician if necessary_____
(Signature of Parent/Guardian) Date

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be confidential.